

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046823  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 178

FILED DEC 3 1963

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>LaClede</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>		Length of stay in 1b <b>27 yr-3 mo</b>	c. CITY OR TOWN <b>Lebanon</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital # 3</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>North Highway 5</b>
3. NAME OF DECEASED (Type or print) First <b>Eva</b>		Middle <b>Zelsman</b>	Last <b>Zelsman</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>	9. AGE (last birthday) <b>75</b>
13a. FATHER'S NAME <b>Thomas C. Lowdermilk</b>		13b. MOTHER'S MAIDEN NAME <b>Mollie Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		17. INFORMANT Address <b>State Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Broncho-pneumonia</b>	
		DUE TO (c) <b>Fracture Rt. Hip- 9-22-63</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY <b>LaClede</b> STATE <b>Mo.</b>
21. I attended the deceased from <b>8-5-63</b> to <b>11-21-63</b> and last saw her alive on <b>11-20-63</b> Death occurred at <b>2:45</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>E. Allen</i> (Deputy Registrar)		22b. ADDRESS <b>St. Hospital Grounds</b>	22c. DATE SIGNED <b>11-21-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11-23-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rose Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Lebanon, LaClede Co., Mo.</b>
24. FUNERAL DIRECTOR <b>J. Shadel</b>	ADDRESS <b>Lebanon, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-30-63</b>	26. REGISTRAR'S SIGNATURE <i>Anna E. Perry</i>

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 5115

P. O. Address Springfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.